History & Physical
08/21/2007

Chief Complaint: Urethral spasm after catheter placement, chest discomfort and continued intractable back pain

History: Patient is a 72-year-old male who was admitted last week. The patient was seen by orthopedic surgery. He was diagnosed with severe spinal stenosis of L3-4. He also had benign prostatic hypertrophy with urinary retention and was seen by Urology. Patient has continued to have back pain at home and is having significant urethral discomfort. His stools have been regular. He denies any fevers or chills. He has had some occasional night sweats. The patient was admitted earlier today and a stress test was ordered. Foley catheter was still in place. Recent urinalysis showed blood but no bacteria. The patient's Cipro he was discharged with will be held. Currently he is not having any chest pain or shortness of breath.

Past Medical History:
1. Severe spinal stenosis at L3-4
2. Hypertension
3. History of benign prostatic hypertrophy with urinary retention

Past Surgical History: Left inguinal hernia repair

Allergies: No known drug allergies

Current Medications:
1. Ciprofloxacin 500 mg p.o. b.i.d.
2. Uroxatrol 10 mg p.o. q. day
3. Avodart 0.5 mg p.o. q. day
4. Captopril 25 mg p.o. b.i.d.
5. Fentanyl 75 mcg p.o. q. 72 hours
6. Hydrochlorothiazide 50 mg p.o. q. day
7. Potassium chloride 10 mEq p.o. q. day
8. Oxycodone 5 mg one to two tabs every 3 hours as needed for pain

Social History: The patient has a history of tobacco use. He used one pack of cigarettes a day for 41 years. He quit smoking 10 to 12 years ago. He occasionally uses alcohol.

Family History: His mother died at age 92 and had significant dementia.
His father was killed in an accident at the age of 37.

Physical Examination:
General Appearance: This is a pleasant, 72-year-old male with minimal discomfort at rest after being given morphine.
Vital Signs: T: 98.1. P: 115. BP: 138/87. R: 20. Room air saturation 94%.
HEENT: Unremarkable
Lungs: Clear

Cardiac: Regular rate and rhythm
Abdomen: Soft, nontender, bowel sounds present. No flank tenderness.
Extremities: No clubbing, cyanosis or edema
Genitalia: Foley catheter is present. There is mild irritation at the urethral meatus.

Laboratory Data: CBC, electrolytes, liver function studies, serum glucose, BUN and creatinine drawn on 08/15/07 are normal.

Recent work-up for the back pain includes an MRI of the lumbar spine along with myelogram and CT.

The patient had an adenosine thallium stress test performed earlier today.

Assessment and Plan:
1. Severe L3-4 spinal stenosis. The patient has been seen by Orthopedics. Surgical intervention appears to be needed.
2. Chest pain. Stress test has been ordered. If this is positive cardiac catheterization will be performed.
3. Urinary retention. Continue with Avodart. Urologist knows the patient and has been consulted. Continue with Foley catheter through the time of surgery. Postop the patient may need straight catheter to eventually get rid of his Foley catheter.

Signed: Family Practice Doctor

Consultation
08/22/2007

Chief Complaint: Urinary retention

History of Present Illness: This is a very pleasant 72-year-old white male with acute urinary retention and a herniated nucleus pulposus at L4-L5. The patient also has a left inguinal hernia. He has had hernias fixed in the past. He has had difficulty voiding for years, but has never seen anybody about it. He gets his prostate checked for cancer once a year at a screening clinic at the medical center closer to his home, may have done a PSA on him, which apparently was normal. The patient denies any stones or any other urinary tract problems, just a lot of symptoms of difficulty voiding for the last several years for which he never sought medical care from anybody. He is admitted to the hospital at this time with a herniated disk. Orthopedics has seen him and will do surgery on his back tomorrow. He has a solitary kidney according to Family Practice notes. I presume this was discovered on some routine x-rays. He had an MRI of the lumbar spine here and he has had no urinary tract x-rays. On laboratory data, his white count is normal. His creatinine is normal at 1.2, blood urea nitrogen is 18. His urinalysis is unremarkable. He has a catheter in place at this time. He had a high residual urine. I would place him on a urinary antibiotic such as Cipro or Bactrim DS and I have ordered that. He needs a PSA done in four days since he had a rectal examination today. I would recommend starting him on Uroxatral and Avodart to see if we can relax his prostate and shrink it.

Physical Examination:
Vital Signs: Stable
HEENT: Normal for age
Neck: Supple, no adenopathy
Chest/Lungs: Clear
Cardiovascular: Regular rhythm
Abdomen: Soft. Left inguinal hernia is present.
Genitourinary: Testicles are normal. Penis is uncircumcised. Foreskin retracts easily. Foley catheter is in place.
Rectal: Good sphincter tone is present. The BC reflex is positive. The prostate is the size of an orange and feels benign.

Recommendations: We will keep him on Cipro 500 b.i.d., keep him on Uroxatral and Avodart, discontinue his catheter after he gets over the surgery and see how well he can void and if he cannot void well he will have to undergo a cystoscopy and urodynamic evaluation in the office with possible transurethral resection of the prostate at a later date. Thank you very much for the consultation. Will follow with you.

Signed: Urologist

Operative Report
08/29/2007

Preoperative Diagnosis: Benign prostatic hypertrophy with obstruction

Postoperative Diagnosis: Benign prostatic hypertrophy with obstruction

Procedure: Cystoscopy and transurethral resection of the prostate

Indications: Benign prostatic hypertrophy with long standing obstruction and acute urinary retention secondary to a combination of factors including back pain and a herniated disk. Patient is still recovering from back surgery. Retention causing enough problems so we decided to go ahead with cystoscopy while still inpatient.

Procedure: In the dorsal lithotomy position under general LMA anesthesia the perineal area was prepped and draped in a routine manner. The #23 Acme cystourethroscope with the Foroblique microlens was introduced into the meatus and advanced toward the bladder. The urethra appeared normal. The prostate exhibited trilobar hyperplasia with complete visual occlusion of the outflow track. The bladder was heavily trabeculated with small cellules and diverticula. No cancer and no stones were seen. Catheter irritation was present on the posterior wall of the bladder, typical for wearing a catheter for as long as he has. The cystoscope was removed. The #28 resectoscope sheath with the Timberlake obturator was introduced into the bladder. The obturator was removed and the Iglesias working element was inserted. The prostate was resected widely. Bleeders were fulgurated with point coagulation. The prostatic chips were irrigated free of the bladder with the Ellik evacuator. The fossa was reinspected. No active arterial bleeders were seen. The bladder was filled up with fluid. The resectoscope was removed. The voiding sign was good and a #24 French 30 cc balloon bag Foley catheter placed for drainage. 40 cc of water was placed into the balloon, irrigated until clear, three-way and he went to the Recovery Room in good condition.

Signed: Urologist

Pathology Report
08/29/2007

Clinical Information: Benign prostatic hypertrophy with retention

Specimen:
Prostate tissue

Gross Description:
The specimen consists of 17 grams of tissue. Representative sections are submitted in Cassettes 1A through 1H for microscopic examination. The remaining specimen is submitted in Cassettes 1I through 1L.

Final Diagnosis:
Tissue from Prostate (initial and additional sections): Focal well to moderately differentiated adenocarcinoma involving one fragment focally out of 111 fragments of prostatic tissue examined.
Glandular and stromal hyperplasia and focal mild acute and chronic inflammation.

Specimen Type: Transurethral prostatic resection
Histologic Type: Adenocarcinoma
Gleason primary pattern: 3
Gleason secondary pattern: 2
Total Gleason score: 5
Percent of prostatic tissue involved by tumor: 1%